

2342

## CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>C.</u> Last <u>Adkins</u>		4. DATE OF DEATH Month <u>Jul.</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31 - 1877</u>
9. AGE (In years last birthday) <u>79 10/13</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Powellville, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Bradford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-09-6129</u>	
17. INFORMANT <u>Mrs. Rosalie J. Giffons</u> Address <u>Snow Hill, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>56</u> , to <u>2/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>312 E. Market St. Snow Hill, Md.</u> DATE SIGNED <u>2/15/57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones M. D.</u>		<u>312 E. Market St. Snow Hill, Md.</u> <u>2/15/57</u>	
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <u>Buried Feb 16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Whateoat Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Dennis</u> ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 18 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Elwyn Cooper</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. 8**

FEB 18 1957

RECEIVED

2343

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>xo Berlin (RURAL)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 Route #3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>CORA E. BRITTINGHAM</b>				4. DATE OF DEATH <b>2 25 1957</b>			
5. SEX <b>F.m.</b>	6. COLOR OR RACE <b>A.A.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-1915</b>	9. AGE (In years lost birthday) <b>41</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTH PLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Cherry</b>				14. MOTHER'S MAIDEN NAME <b>Sally V. Heath</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>215-26-5392</b>		17. INFORMANT <b>Charles Brittingham, Berlin, Md Rt #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential hypertension</b> DUE TO (c) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b> <b>1 1/2 yrs</b> <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/26 1955</b> , to <b>1/22 1957</b> , that I last saw the deceased alive on <b>1/22 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ivory V. Sully</b> M.D.				ADDRESS (Street, city or town, state) <b>Flower St Berlin Md</b>			
DATE SIGNED <b>2/25/57</b>							
PHYSICIAN'S NAME (Type) <b>Ivory V. Sully</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>African Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cheriton, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart</b>				ADDRESS <b>Funeral Home Salisbury, Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 5 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Helen F. Hayward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>1900-01-01</i></p>		<p>4. Date of death: <i>1950-01-01</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Place of death: <i>Baltimore, Md.</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Date of registration: <i>1950-01-01</i></p>		<p>12. Office of registration: <i>Baltimore, Md.</i></p>	

BUREAU

MAR 4

RECEIVED

# 1 2340 Itme 12 Film 3210 2-11-57 et 2340 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12354  
350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke City,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Ginn</u> Middle <u>Collins</u> Last				4. DATE OF DEATH <u>February</u> Month <u>2</u> Day <u>1957</u> Year			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Mary Pitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Marshall</u>		Address <u>Stockton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X</u> DUE TO <u>Tuberculosis of the Lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>D.K.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>Feb. 1st.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 1st.</u> , 19 <u>57</u> , and that death occurred at <u>6 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. E. Sartorius</u>		M.D. <u>Pocomoke City, Md.</u>		ADDRESS (Street, city or town, state) <u>2357</u>		DATE SIGNED <u>2-3-57</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>2/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
CERTIFICATE OF DEATH

BUREAU V. S.

FEB 8 1957

RECEIVED

2344  
CERTIFICATE OF DEATH

Reg. Dist. No. 358-

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			c. LENGTH OF STAY IN 1b <b>14 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 BERLIN</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 BROAD ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLA TOWNSEND CROPPER</b>				4. DATE OF DEATH Month Day Year <b>FEB 23 1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 10, 1870</b>		9. AGE (In years last birthday) <b>87</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD. R.F.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSIAH TOWNSEND</b>				14. MOTHER'S MAIDEN NAME <b>LETITIA VAN DOGH.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>MR. SIDNEY CROPPER NEWARK MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Dilated Heart</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Hypertension &amp; arteriosclerosis</b> DUE TO (c) <b>Age.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1, 1956</b> , to <b>Feb 23, 1957</b> , that I last saw the deceased alive on <b>Feb 23, 1957</b> , and that death occurred at <b>4:40 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. R. Law</b> M.D.				ADDRESS (Street, city or town, state) <b>Berlin Md</b> DATE SIGNED <b>Feb 23 - 1957</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>		22d. LOCATION (City, town, or county) (State) <b>NEWARK MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Busbaga</b> ADDRESS <b>Berlin Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 2/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>Stelan + Stayward</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 26 1957

BUREAU V. 3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE: [illegible]

2345

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>BERLIN (RURAL)</u>				c. LENGTH OF STAY IN 1b <u>All her life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>Ellen</u> Last <u>Cutler</u>				4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>F.M.</u>		6. COLOR OR RACE <u>A.A.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-21-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WORK</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George B. Hammond</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Selby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-09-5895</u>		17. INFORMANT <u>Mrs PAULINE C PARNELL—Berlin, Md, Rt #5</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Essential hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>23</u> <u>Several yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. p. m. <u>19</u> Month, Day, Year				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/4</u> 19 <u>56</u> , to <u>2/21</u> 19 <u>57</u> , that I last saw the deceased alive on <u>2/21</u> 19 <u>57</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest N. Shelly, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin, Md</u>			
DATE SIGNED <u>2/23/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin (Rt #2) Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart Funeral Home</u> ADDRESS <u>Salisbury, Md</u>							
24a. REC'D BY REGISTRAR <u>MAR 5 1957</u>				24b. REGISTRAR'S SIGNATURE <u>Robert F. Raymond</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

BUREAU V. 3

MAR 4 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02357 358

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 BERLIN RFD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1 CHANGY TOWN IN</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES HUGER DENNIS</b>		4. DATE OF DEATH Month Day Year <b>FEB 16 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 8, 1893</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHICKEN PLANT</b>	
11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN DENNIS</b>		14. MOTHER'S MAIDEN NAME <b>MAY BROOKMAR.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-26-3542</b>	
17. INFORMANT <b>MR. IVAN DENNIS CHINCOTEAGE VA</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816X Shock</b> DUE TO (b) <b>Fracture of Cervical Spine - Fracture of 2-3-4 &amp; Rib, Left Cost. &amp; Comp. of Chest.</b> DUE TO (c) <b>Chest.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instantly to minute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Head on Collision, off Rt 50, Completion Rt, Worcester Co.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:15 a.m. Feb 16 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>off Rt 50</b>	20f. (City or town) (County) (State) <b>St. Martins Worcester Co. Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Herman A. Robbins</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Herman A. Robbins M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>TAYLORVILLE</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN (RFD. MD)</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burdette Berlin Md</b>		24a. REC'D BY REGISTRAR <b>FEB 20 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>John F. Hayward</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

FEB 20 1957

RECEIVED

Item 7 FilmG211 2-25-57 et

2347

## CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Maryland</u> <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hattie</u> <u>E. Foreman</u>				4. DATE OF DEATH <u>February 4</u> <u>19 57</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 15 1899</u> <u>58</u> yrs.	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Saunders Horsey</u>				14. MOTHER'S MAIDEN NAME <u>Lovie Brittingham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stockton, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> <u>Generalized Convulsions</u> DUE TO <u>Convulsion of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2.</u> (c) <u>2.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/22</u> , 19 <u>56</u> , to <u>2/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>57</u> , and that death occurred at <u>5:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u>				ADDRESS (Street, city or town, state) <u>Shawkeel, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Thomas L. Jones, M.D.</u>				DATE SIGNED <u>2/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Foreman Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar or Overhatter N</u>				ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>2/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Elmer E. Cooper</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		MORBIDITY		MORTALITY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

BUREAU V. S.

1057

RECEIVED

*Handwritten signature and notes at the bottom of the page.*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02359

2348

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Mercer</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mercer</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Snow Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Sillett</u> Last <u>Sillett</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27-1904</u>	9. AGE (In years last birthday) <u>52/10/25</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u>25</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Safari</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Woods</u>		11. BIRTHPLACE (State or foreign country) <u>New Church, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Sillett</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Audrey Holland</u>		Address <u>Snow Hill, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(?) accidental or homicide</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Coke</u>	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		DATE SIGNED <u>2/25/57</u>					
22a. BURIAL, CREMATION, or OTHER DISPOSAL (Specify) <u>Burial Feb 24/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or county) <u>Snow Hill</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Davis</u>		ADDRESS <u>Snow Hill, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elwyn Casper</u>	

MEDICAL CERTIFICATION

23

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

RECEIVED

FEB 27 1957

BUREAU V. S.

02369  
253

2349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishop</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishop</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Isaiah</b> Middle <b>Harmon</b> Last <b>Harmon</b>		4. DATE OF DEATH <b>3 Feb.</b> 3 <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1908</b> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Isaac Parker</b>		14. MOTHER'S MAIDEN NAME <b>Martha Harmon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-4351</b>	
17. INFORMANT <b>Ella Purnell, Bishop, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute endocarditis</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr Nephritis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>430.1</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 14 - 1957</b> , to <b>Feb 3 - 1957</b> , that I last saw the deceased alive on <b>Feb 1 - 1957</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. P. Berlin</b> M.D.		DATE SIGNED <b>2-4-57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sarah Dukes</b>	22d. LOCATION (City, town, or county) (State) <b>Bishop, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		24a. REC'D BY REGISTRAR <b>Feb 7 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Edna R. Burgess</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02362  
350

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. LENGTH OF STAY IN 1b <u>minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City 19X22</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Market Street</u>				d. STREET ADDRESS <u>RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Peacock</u>				4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 16, 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Peacock</u>				14. MOTHER'S MAIDEN NAME <u>Ester Ann Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-3594</u>		17. INFORMANT Address <u>Mrs Alice E. Peacock, Pocomoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ejection</u> INTERVAL BETWEEN ONSET AND DEATH <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. Sartorius Sr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 1 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Gene H. Hester</u>	

MEDICAL CERTIFICATION

NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 1 1957

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# STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0212 3-11-57 et

2350

## CERTIFICATE OF DEATH

Reg. Dist. No.

02363  
351

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WORCESTER</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL</u> c. LENGTH OF STAY IN 1b <u>31 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>WORCESTER</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SNOW HILL, MD x 2</u> d. STREET ADDRESS <u>203 Willow St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nellie K. Richardson</u>				<b>4. DATE OF DEATH</b> <u>Feb 27 1957</u>			
<b>5. SEX</b> <u>F.M.</u>		<b>6. COLOR OR RACE</b> <u>A.A.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-2-1885</u>	
<b>9. AGE</b> (In years last birthday) <u>72 1/2</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SEASONAL WORK</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>FACTORY</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>NORTH CAROLINA</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Shaper Kerney</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Amy Ewell</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>219-03-768</u>		<b>17. INFORMANT</b> <u>Mr. Lee Richardson</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. p. m. _____ 19____			
<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____			
<b>20f. (City or town)</b> _____				<b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that I attended the deceased from</b> <u>2/22/57</u> , 19____, <b>to</b> <u>2/27/57</u> , 19____, <b>that I last saw the deceased alive on</b> <u>2/26/57</u> , 19____, <b>and that death occurred at</b> <u>3:00 P.M.</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Robert C. La Mar</u>				<b>ADDRESS</b> (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>ROBERT C. LA MAR, M.D.</u>				<b>DATE SIGNED</b> <u>3/1/57</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>3-3-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Ant. Zion Baptist Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) <u>SNOW HILL, MD</u> <span style="float: right;">(State)</span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Stewart</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Blugyn Cooper</u>			
<b>ADDRESS</b> <u>Funeral Home, Salisbury, MD</u>				<b>DATE</b> <u>6 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		FIREARMS		DR. JAMES H. HARRIS	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		4		10		00		98.6		60	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE		ADDRESS		CITY	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		DECEASED		1000 ...		MEMPHIS	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		TITLE		ADDRESS		CITY	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		DECEASED		1000 ...		MEMPHIS	

BUREAU V. 3

MAR 6 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02364

2351

## CERTIFICATE OF DEATH

Reg. Dist. No.

251

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Shackley</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1 - 1871</u>
9. AGE (In years last birthday) <u>86 1/2</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockton, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Brown</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Nettie Hayden</u>		Address <u>Stockton, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia &amp; Emaciation</u> DUE TO (b) <u>Metastatic Carcinoma of the Breast</u> DUE TO (c) <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>54</u> to <u>Feb 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 20</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St</u> DATE SIGNED <u>2-23-57</u>			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		DATE SIGNED <u>2-23-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>		<u>Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 25/57</u>		22b. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>	
22c. LOCATION (City, town, or county) (State) <u>Stockton md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Harris</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Elmer Cooper</u>	

BUREAU V. S.

FFB 25 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2352 CERTIFICATE OF DEATH

Reg. Dist. No.

02365, 251

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
c. LENGTH OF STAY IN 1b <u>57 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>La</u> Last <u>Smack</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5 - 1899</u>
9. AGE (In years last birthday) <u>57 7/4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Hals</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>517-05-7597</u>	
17. INFORMANT Address <u>Willmaunce C. Smack, Snow Hill, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia + Inanition</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno Carcinoma of Rectum</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1</u> , 19 <u>55</u> , to <u>Feb 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 8</u> , 19 <u>57</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Sumner</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR <u>FEB 13 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Elwyn Cooper</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
EDUCATION		RELIGION		PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY	
DATE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 3

FEB 13 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2353

## CERTIFICATE OF DEATH

02366

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver M Sullivan</u>		4. DATE OF DEATH <u>Feb 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11-1879</u>
9. AGE (In years last birthday) <u>77 1/2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William S. Riley</u>		14. MOTHER'S MAIDEN NAME <u>Emily Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. J. Russell Stagg</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Breast - metastases</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>16 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1</u> , 1956, to <u>Feb 19</u> , 1957, that I last saw the deceased alive on <u>Feb 19</u> , 1957, and that death occurred at <u>9:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 Bay St</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>		DATE SIGNED <u>2-20-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton E. Dennis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR <u>Feb 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clayton E. Dennis</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH _____		COUNTY _____	
NAME OF DECEASED _____		SEX _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF BIRTH _____		AGE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MEDICAL HISTORY _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	

BUREAU V. S.

FEB 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2354

## CERTIFICATE OF DEATH

02367

Reg. Dist. No. 332

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X / Eden (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 21</b>		d. STREET ADDRESS <b>/ R.D.# 21</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>KING</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10th</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1872</b>
9. AGE (In years last birthday) <b>84 79</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William H. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Pusey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs. Elizabeth D. Wilson (Wife)</b>		Address <b>R.D.# 2 Eden, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>10</b> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-6</b> , 19 <b>57</b> , to <b>2-10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>2-6</b> , 19 <b>57</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl L. Royer</b>		ADDRESS (Street, city or town, state) <b>Camden Ave. (Office)</b> DATE SIGNED <b>Feb. 11 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>		M.D. <b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 13, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>2/14/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>			

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE (Print or Write)		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
AGE YEARS MONTHS DAYS (Print or Write)		DATE OF BIRTH YEAR MONTH DAY (Print or Write)	
PLACE OF BIRTH (Print or Write)		PLACE OF DEATH (Print or Write)	
OCCUPATION (Print or Write)		CAUSE OF DEATH (Print or Write)	
MANNER OF DEATH (Print or Write)		MEDICAL HISTORY (Print or Write)	
PRESENT ILLNESS (Print or Write)		PREVIOUS ILLNESS (Print or Write)	
PHYSICIAN'S SIGNATURE (Print or Write)		MEDICAL EXAMINER'S SIGNATURE (Print or Write)	
DATE OF DEATH YEAR MONTH DAY (Print or Write)		TIME OF DEATH (Print or Write)	
PLACE OF INTERMENT (Print or Write)		NAME OF FUNERAL HOME (Print or Write)	
SIGNATURE OF REGISTRAR (Print or Write)		OFFICIAL SEAL (Print or Write)	

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